EDMUND G. BROWN JR.
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
BRIAN S. TURNER
Deputy Attorney General
State Bar No. 108991
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-0603
Facsimile: (916) 327-8643
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In In the Matter of the Accusation Against: **CLARA C. WILLIAMS** **1114 Oakleaf Drive** **Savannah, GA 31410** **Registered Nurse License No. 673563** Respondent.	Case No. 2011-776 **DEFAULT DECISION AND ORDER** [Gov. Code, §11520]

FINDINGS OF FACT

1. On or about March 16, 2011, Complainant Louise R. Bailey, M.Ed., RN, in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs, filed Accusation No. 2011-776 against Clara C. Williams (Respondent) before the Board of Registered Nursing (Board). (Accusation attached as Exhibit A.)

2. On or about February 14, 2006, the Board issued Registered Nurse License No. 673563 to Respondent. The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2011, unless renewed.

3. On or about March 16, 2011, Respondent was served by certified and first class mail with copies of the Accusation No. 2011-776, Statement to Respondent, Request for Discovery, Notices of Defense and copies of Government Code sections concerning discovery at

Respondent's address of record which, pursuant to California Code of Regulations, title 16, section 1409.1, is required to be reported and maintained with the Board, which was and is: 1114 Oakleaf Drive, Savannah, Georgia 31410.

4. Service of the Accusation was effective as a matter of law under the provisions of Government Code section 11505, subdivision (c) and/or Business & Professions Code section 124.

5. On or about March 28, 2011, the aforementioned documents were returned by the U.S. Postal Service marked address vacant. The address on the documents was the same as the address on file with the Board. Respondent failed to maintain an updated address with the Board and the Board has made attempts to serve the Respondent at the address on file. Respondent has not made herself available for service and therefore, has not availed herself of her right to file a notice of defense and appear at hearing.

6. Government Code section 11506 states, in pertinent part:

> (c) The respondent shall be entitled to a hearing on the merits if the respondent files a notice of defense, and the notice shall be deemed a specific denial of all parts of the accusation not expressly admitted. Failure to file a notice of defense shall constitute a waiver of respondent's right to a hearing, but the agency in its discretion may nevertheless grant a hearing.

7. Respondent failed to file a Notice of Defense within 15 days after service upon her of the Accusation, and therefore waived her right to a hearing on the merits of Accusation No. 2011-776.

8. California Government Code section 11520 states, in pertinent part:

> (a) If the respondent either fails to file a notice of defense or to appear at the hearing, the agency may take action based upon the respondent's express admissions or upon other evidence and affidavits may be used as evidence without any notice to respondent.

9. Pursuant to its authority under Government Code section 11520, the Board finds Respondent is in default. The Board will take action without further hearing and, based on the relevant evidence contained in the Default Decision Evidence Packet in this matter, as well as taking official notice of all the investigatory reports, exhibits and statements contained therein on file at the Board's offices regarding the allegations contained in Accusation No. 2011-776, finds

that the charges and allegations in Accusation No. 2011-776, are separately and severally, found to be true and correct by clear and convincing evidence.

10. Taking official notice of its own internal records, pursuant to Business and Professions Code section 125.3, it is hereby determined that the reasonable costs for Investigation and Enforcement is $7,825.00 as of April 15, 2011.

DETERMINATION OF ISSUES

1. Based on the foregoing findings of fact, Respondent Clara C. Williams has subjected her Registered Nurse License No. 673563 to discipline.

2. The agency has jurisdiction to adjudicate this case by default.

3. The Board of Registered Nursing is authorized to revoke Respondent's Registered Nurse License based upon the following violations alleged in the Accusation which are supported by the evidence contained in the Default Decision Evidence Packet in this case.:

a. Obtain and Possess Controlled Substances In Violation of Law constituting Unprofessional Conduct as set forth in Business and Professions Code section 2762(a)

b. Falsify or Make Grossly Incorrect Entriesin Patient/Hospital Records constituting Unprofessional Conduct as set forth in Business and Professions Code section 2762(e)

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ORDER

IT IS ORDERED that Registered Nurse License No. 673563, heretofore issued to Respondent Clara C. Williams, is revoked.

Pursuant to Government Code section 11520, subdivision (c), Respondent may serve a written motion requesting that the Decision be vacated and stating the grounds relied on within seven (7) days after service of the Decision on Respondent. The agency in its discretion may vacate the Decision and grant a hearing on a showing of good cause, as defined in the statute.

This Decision shall become effective on July 8, 2011.

It is so ORDERED June 10, 2011.

Jeannie K. Glover

FOR THE BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS

default decision_LIC.rtf
DOJ Matter ID:SA2010102480

Attachment:
Exhibit A: Accusation

Exhibit A

Accusation

EDMUND G. BROWN JR.
Attorney General of California
ARTHUR D. TAGGART
Supervising Deputy Attorney General
BRIAN S. TURNER
Deputy Attorney General
State Bar No. 108991
1300 I Street, Suite 125
P.O. Box 944255
Sacramento, CA 94244-2550
Telephone: (916) 445-0603
Facsimile: (916) 327-8643
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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **CLARA C. WILLIAMS** **1114 Oakleaf Drive** **Savannah, GA 31410** **Registered Nurse License No. 673563** Respondent.	Case No. 2011-776 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about February 14, 2006, the Board issued Registered Nurse License Number 673563 to Clara C. Williams ("Respondent"). The registered nurse license was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2011, unless renewed.

STATUTORY PROVISIONS

3. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an

inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

4. Code section 2764 provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

5. Code section 2761 states, in pertinent part:

> The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:
>
> (a) Unprofessional conduct....,

6. Code section 2762 states, in pertinent part:

> In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:
>
> (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.
>
> (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

COST RECOVERY

7. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

8. **CONTROLLED SUBSTANCES**

"Morphine" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(1)(M), and a dangerous drug pursuant to Code section 4022, in that under federal and state law it requires a prescription.

"Percocet" is a brand of oxycodone and is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b)(N), and a dangerous drug pursuant to Business and Professions Code section 4022, in that under federal and state law it requires a prescription.

"Promethazine" is a Schedule V controlled substance pursuant to Health and Safety Code section 11058, and a dangerous drug pursuant to Code section 4022, in that under federal and state law it requires a prescription.

"Tylenol #3" is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(2), and a dangerous drug pursuant to Code section 4022, in that under federal and state law it requires a prescription.

"Vicodin" is a brand of hydrocodone and is a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e)(4), and a dangerous drug pursuant to Code section 4022, in that under federal and state law it requires a prescription.

FIRST CAUSE FOR DISCIPLINE

(Obtain and Possess Controlled Substances in Violation of Law)

9. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (a), in that between February 20, 2008, and March 2, 2008, while on duty as a registered nurse at Coalinga Regional Medical Center, Coalinga, California, Respondent committed the following acts:

a. Respondent obtained the controlled substances Morphine, Percocet, Promethazine, Tylenol 3, and Vicodin, by fraud, deceit, misrepresentation, or subterfuge by taking the drugs from hospital supplies in violation of Health and Safety Code section 11173, subdivision (a).

b. Respondent possessed the controlled substances Morphine, Percocet, Promethazine, Tylenol 3, and Vicodin, without lawful authority in violation of Code section 4022.

SECOND CAUSE FOR DISCIPLINE

(Falsify, or Make Grossly Incorrect Entries in Patient/Hospital Records)

10. Respondent is subject to discipline pursuant to Code section 2761, subdivision (a), on the grounds of unprofessional conduct, as defined in Code section 2762, subdivision (e), in that

between February 20, 2008, and March 2, 2008, while on duty as a registered nurse at Coalinga Regional Medical Center, Coalinga, California, Respondent falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in the following patient/hospital records:

Patient A

a. On February 22, 2008, at 0806 hours, Respondent withdrew 1 Vicodin APAP tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

b. On February 22, 2008, at 1259 hours, Respondent withdrew 1 Vicodin APAP tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

c. On February 22, 2008, at 1308 hours, Respondent withdrew 2 Promethazine w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Promethazine w/codeine in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

d. On February 23, 2008, at 1030 hours, Respondent withdrew 1 Vicodin APAP tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

e. On February 23, 2008, at 1404 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

f. On February 23, 2008, at 1456 hours, Respondent withdrew 2 Promethazine w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Promethazine w/codeine in the patient's

medication administration record or otherwise account for the disposition of the drug in any hospital record.

g. On February 24, 2008, at 0730 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

h. On February 24, 2008, at 0731 hours, Respondent withdrew 2 Promethazine w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Promethazine w/codeine in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

i. On February 24, 2008, at 1058 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

j. On February 24, 2008, at 1240 hours, Respondent withdrew 2 Promethazine w/codeine 5 ml cups from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Promethazine w/codeine in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

k. On February 24, 2008, at 1520 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

l. On February 26, 2008, at 1217 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

m. On February 26, 2008, at 1348 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient B

n. On February 29, 2008, at 1843 hours, Respondent withdrew 1 VicodinAPAP tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient C

o. On February 29, 2008, at 1400 hours, Respondent withdrew 1 Morphine Sulfate 2mg/1ml syringe from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Morphine Sulfate in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient D

p. On February 22, 2008, at 1832 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

q. On February 23, 2008, at 0733 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

r. On February 23, 2008, at 1204 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

s. On February 23, 2008, at 1808 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

t. On February 24, 2008, at 0928 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

u. On February 24, 2008, at 1419 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

v. On February 24, 2008, at 1827 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

w. On February 26, 2008, at 0743 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

x. On February 26, 2008, at 1101 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

y. On February 26, 2008, at 1157 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient E

z. On February 26, 2008, at 0912 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient F

aa. On February 20, 2008, at 1443 hours, Respondent withdrew 2 Percocet tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Percocet in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient H

bb. On March 1, 2008, at 1019 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

cc. On March 1, 2008, at 1733 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

dd. On March 2, 2008, at 0740 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

ee. On March 2, 2008, at 1108 hours, Respondent withdrew 2 Vicodin APAP tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Vicodin in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient I

ff. On March 1, 2008, at 1146 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

gg. On March 1, 2008, at 1732 hours, Respondent withdrew 2 Tylenol #3 tablets from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

Patient J

hh. On February 29, 2008, at 0745 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

ii. On February 29, 2008, at 0953 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

jj. On February 29, 2008, at 1149 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

kk. On February 29, 2008, at 1149 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

ll. On February 29, 2008, at 1358 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of

any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

mm. On February 29, 2008, at 1358 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

nn. On February 29, 2008, at 1524 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

oo. On February 29, 2008, at 1745 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

pp. On February 29, 2008, at 1746 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

qq. On March 1, 2008, at 1001 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

rr. On March 1, 2008, at 1002 hours, Respondent withdrew 1 Tylenol #3 tablet from the Pyxis system for this patient; however, Respondent failed to document the administration of any portion of the Tylenol #3 in the patient's medication administration record or otherwise account for the disposition of the drug in any hospital record.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 673563, issued to Clara C. Williams;

2. Ordering Clara C. Williams to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: 3/16/11

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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